PRINTED: 09/22/2011

EPARTMENT	FORM APPROVED							
ENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-0391	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		155785	B. WING			09/06/2	011	
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
TVINIE OF T	KO VIDEK OK SOIT EIEK			714 S EICKHOFF ROAD				
WEST RIVER HEALTH CAMPUS				EVANS'	VILLE, IN47712			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	

WEST F	RIVER HEALTH CAMPUS	EVANSVILLE, IN47712				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F0000						
	This visit was for Investigation of	F0000				
	Complaint IN00095419.					
	Complaint IN00095419 - Substantiated.					
	Federal/state deficiencies related to the					
	allegations are cited at F203, F205 and R045.					
	Survey date: 9/6/11					
	Facility number: 012448					
	Provider number: 155785					
	AIM number: N/A					
	Survey team: Jennie Bartelt, RN					
	Census bed type:					
	SNF: 23					
	Residential: 44					
	Total: 67					
	Census payor type:					
	Medicare: 15					
	Other: 52					
	Total: 67					
	Sample: 5					
	Residential sample: 1					
	These deficiencies reflect state findings					
	cited in accordance with 410 IAC 16.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TDYW11

Facility ID:

012448

PRINTED: 09/22/2011 FORM APPROVED OMB NO. 0938-0391

1		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/06/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF ROAD EVANSVILLE, IN47712				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEPICIENCY)	ΓE	(X5) COMPLETION DATE
	<u> </u>	/07/11 by Suzanne		5			25

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TDYW11 Facility ID:

012448

If continuation sheet

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED			
ANDILAN	or correction	155785	A. BUILDING		09/06/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			EICKHOFF ROAD	
WEST RI	VER HEALTH CAM			VILLE, IN47712	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
PREFIX				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG		· · · · · · · · · · · · · · · · · · ·	IAG	DEFEIENCT)	DATE
F0203 SS=D		ansfers or discharges a y must notify the resident			
33-D		mily member or legal			
		he resident of the transfer			
	_	he reasons for the move in			
		nguage and manner they			
		d the reasons in the record; and include in the			
		escribed in paragraph (a)(6)			
	of this section.	1 3 1 ( )( )			
		ified in paragraph (a)(5)(ii) notice of transfer or			
		d under paragraph (a)(4) of			
		be made by the facility at			
	least 30 days befo				
	transferred or disc	harged.			
	Notice may be ma	de as soon as practicable			
		discharge when the health			
	of individuals in the	_			
	-	(a)(2)(iv) of this section;			
		th improves sufficiently to			
		ediate transfer or discharge,			
		a)(2)(i) of this section; an ror discharge is required by			
		ent medical needs, under			
	_	) of this section; or a			
		esided in the facility for 30			
	days.				
	The written notice	specified in paragraph (a)			
		must include the reason for			
	transfer or dischar	ge; the effective date of			
		ge; the location to which the			
		red or discharged; a			
		resident has the right to to the State; the name,			
		hone number of the State			
		budsman; for nursing			
	facility residents w				
	disabilities, the ma	iling address and telephone			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  155785	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  OO COMPLETED				
II 1007 00 I		09/06/2011			
B. WING		09/00/2011			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CI  744 S. FICKLIOFE					
	714 S EICKHOFF ROAD EVANSVILLE, IN47712				
		T (7/5)			
	OVIDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
	EFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE			
number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act, and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.  Based on record review and interview, the facility failed to ensure residents were issued a Notice of Transfer or Discharge for 2 of 4 residents reviewed related to discharge to inpatient hospitalization in a sample of 5 residents. (Residents B and C)  Findings include:  1. The closed clinical record for Resident C was reviewed on 9/6/11 at 2:15 p.m.  Nurse's Notes on 8/19/11 at 1:45 [a.m. or p.m. not indicated] indicated, "CNA reported 'res. [resident] not acting right.'  Res assessedDr. [name of physician] notified; Orders received from on-call MD to send res to [name of local hospital]. Daughter arrived & requested res be sent out to ER [emergency room]"	esidents B and C suffer fects from the alleged ncy as stated in the all residents have the all to be affected and in inservice and alteration ures will ensure that no sfer/discharge is issued transfer and contains a dinformation. Completion 0-6-11 Systemic change use of a notice of transfer and contact at information and a rge/Bedhold Policy signission. Completion Date 1 Staff inserviced on r/discharge notice and ement to notify legal entative at time of r. Completion Date 1 Director of Social es/Designee will monito r forms daily and comfinitification occurs at time r. Results of monitoring warded to QA committee y x 6 months and quarter	red 10/06/2011  on in otice lat all on e will fer s  ned e			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155785	A. BUI	LDING	00	09/06/2	
		155765	B. WIN			09/00/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WEST R	IVER HEALTH CAM	IPUS		1	EICKHOFF ROAD VILLE, IN47712		
					· · · · · · · · · · · · · · · · · · ·		(V.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL.		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG CROSS-REFERENCED TO THE APPROPRIA		TE	DATE
	Transfer and Dis	charge was issued to the	İ				
		ne of transfer to the					
	hospital.						
	•						
	2. The closed cli	inical record for Resident					
	B was reviewed	on 9/6/11 at 2:35 p.m.					
		1					
	Nurse's Notes on	the Skilled Nursing					
		Data Collection form,					
	dated 5/26/11 at	12:00 noon indicated,					
	"During transfer	res. became					
	unresponsiveDr. [name of physician]						
	here et [and] resi	dent assessed. N.O.					
	[new order] to m	onitor res et if symptoms					
	do not resolve to	send to [name of local					
	hospital] ER for	eval [evaluation]." Notes					
	on 5/26/11 at 1:0	0 p.m. indicated the					
	resident was tran	sferred by ambulance to					
	the hospital.						
	Documentation i	n the closed record file					
	folder failed to ir	ndicate a Notice of					
		charge was issued to the					
	resident at the tir	ne of transfer to the					
	hospital.						
	_	on 9/6/11 at 3:50 p.m.,					
		ocial Services indicated					
	1 ^	e Notice of Transfer and					
	ı	sident has a planned					
	· -	s a discharge home, but					
	_	ıld complete the Notice					
		Discharge if a resident is					
	transferred to the	emergency room.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155785		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	` ′	e survey pleted /2011	
	PROVIDER OR SUPPLIER		714 S	ADDRESS, CITY, STATE, ZIP C EICKHOFF ROAD SVILLE, IN47712	ODE	
WEST RI (X4) ID PREFIX TAG	During interview the Executive Di should complete and Discharge as paperwork sent t resident and mair resident's clinica indicated the Nor Discharge for Renot be located.  This federal tag is IN00095419.  3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C)	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  Ton 9/6/11 at 4:30 p.m., rector indicated the nurse the Notice of Transfer part of the transfer to the hospital with the intain a copy for the I record. She also tice of Transfer and sidents B and C could  s related to Complaint			HOULD BE	(X5) COMPLETION DATE
	3.1-12(a)(9)(D) 3.1-12(a)(9)(E) 3.1-12(a)(9)(F) 3.1-12(a)(9)(G)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785			(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 09/06/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE EICKHOFF ROAD	
WEST RI	VER HEALTH CAM	IPUS		VILLE, IN47712	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F0205 SS=D	Before a nursing for a hospital or allow therapeutic leave, provide written information a family member of specifies the durate under the State planesident is permitted resident is permitted resident in periods, which murparagraph (b)(3) or resident to return.  At the time of transposition or the facility must provide family member or notice which specified bed-hold policy designation of the facility failed to a copy of the facture upon discharge the hospitalization for reviewed related of 5 residents. (If Findings include 1. The closed clity C was reviewed on the facture of the factu	acility transfers a resident to s a resident to go on the nursing facility must brantion to the resident and or legal representative that the tion of the bed-hold policy an, if any, during which the ed to return and resume tursing facility, and the colicies regarding bed-hold st be consistent with a fifth section, permitting a sefer of a resident for the resident and a legal representative written a	F0205	F205Residents B,C and F suffered no ill effects from the alleged deficiency as stated 2567. All residents have the potential to be affected and through inservice and alterat procedures will ensure that no f transfer/discharge is issue time of transfer and contains required information. Comple Date 10-6-11Systemic chanwill be the use of a notice of transfer or discharge form the contains the local ombudsma contact information and a Discharge/Bedhold policy sigon admission. Completion Dato-6-11Staff inserviced on transfer/discharge notice and requirement to notify legal representative at time of	e in the ion in notice ad at all tion ge at an gned ate

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TDYW11 Facility ID: 012448

If continuation sheet Page 7 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155785	B. WIN			09/06/2	011
		l .	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			EICKHOFF ROAD		
WEST R	IVER HEALTH CAM	MPUS .		1	VILLE, IN47712		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE	
	notified; Orders	received from on-call			transfer.Completion Date		
	MD to send res t	to [name of local			10-6-11Director of Social		
	hospital]. Daugl	hter arrived & requested			Services/Designee will monit transfer forms daily and conf		
	res be sent out to	•			that notification occurs at tim		
	room]"				transfer.Results of monitoring		
	100111]				be forwarded to QA committee		
	Documentation	in the closed record file			monthly x 6 months and qua	rterly	
					thereafter.		
		ndicate a copy of the					
	1 -	old Policy was issued to					
		e time of transfer to the					
	hospital.						
	2. The closed cl	inical record for Resident					
	B was reviewed	on 9/6/11 at 2:35 p.m.					
	Nurse's Notes or	the Skilled Nursing					
		Data Collection form,					
		12:00 noon indicated,					
	"During transfer	· · · · · · · · · · · · · · · · · · ·					
	_						
	_	Or. [name of physician]					
		ident assessed. N.O.					
	] "	nonitor res et if symptoms					
		send to [name of local					
	hospital] ER for	eval [evaluation]." Notes					
	on 5/26/11 at 1:0	00 p.m. indicated the					
	resident was tran	sferred by ambulance to					
	the hospital.						
	Documentation i	in the closed record file					
		ndicate a copy of the					
		old Policy was issued to					
	1	-					
		e time of transfer to the					
	hospital.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILI		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155785	B. WING			09/06/2	011
	PROVIDER OR SUPPLIER			714 S E	DDRESS, CITY, STATE, ZIP CODE ICKHOFF ROAD		
	IVER HEALTH CAM				VILLE, IN47712		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PERCEDED BY FULL		P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE.	(X5) COMPLETION DATE
		nical record for Resident on 9/6/11 at 12:50 p.m.					
	The record include Transfer or Discharged to a lounit. The third positiled, "Nursing Forms The second section labeled "Facility blank. The fourth was labeled "Not Discharge Requesection of the pagunchecked entry bed hold policy." to indicate the Begrovided to the result of the Executive Discharge Requesection of the pagunchecked entry bed hold policy." The Executive Discharge Requesection of the pagunchecked entry bed hold policy. The Executive Discharge Requesection of the pagunchecked entry bed hold policy. The Executive Discharge indicated to the indicated the in June 2011, according the Begroviding the Begrovid	ded a copy of Notice of harge, dated 8/2/11, the resident was ocal inpatient behavior age of the document was facility Bed Hold Policy." on of this page was bed hold policy" and was the page of the document tice of Transfer or st for Hearing." The last age indicated an labeled, "Attach facility Documentation failed the Hold Policy had been resident.  Ton 9/6/11 at 4:30 p.m., rector indicated she was the facility's current discharge and bed holds. Spolicy had been revised fording to the facility's Consultant. She also information related to					
	This federal tag IN00095419.	is related to Complaint					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TDYW11 Facility ID: 012448

If continuation sheet

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PRINTED: 09/22/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPI	LETED
		155785	B. WIN			09/06/2	011
NAME OF PROVIDER OR SUPPLIER  WEST RIVER HEALTH CAMPUS		<u> </u>	P	STREET A	ADDRESS, CITY, STATE, ZIP CODE EICKHOFF ROAD VILLE, IN47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	H CORRECTIVE ACTION SHOULD BE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)				DATE
	3.1-12(a)(25)(A) 3.1-12(a)(25)(B)						
R0000		sidential finding is cited ith 410 IAC 16.2-5.	R0	0000			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TDYW11 Facility ID:

012448

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A PLUI DING OO COMPLETED		
		155785	A. BUILDING		09/06/2011
		100.00	B. WING		00/00/2011
NAME OF P	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
			714 S	EICKHOFF ROAD	
	VER HEALTH CAM	IPUS	EVANSVILLE, IN47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R0045	(6) Before an inter	facility transfer or discharge			
	occurs, the facility	must, on a form prescribed			
	by the department	, do the following:			
	(A) Notify the resid	dent of the transfer or			
	discharge and the	reasons for the move, in			
	writing, and in a la	nguage and manner that			
	the resident under	stands. The health facility			
	must place a copy	of the notice in the resident			
	's clinical record a	and transmit a copy to the			
	following:				
	(i) The resident.				
	(ii) A family memb	er of the resident if known.			
	(iii) The resident 's legal representative if				
	known.				
	(iv) The local long	term care ombudsman			
	program (for involu	untary relocations or			
	discharges only).				
	(v) The person or	agency responsible for the			
	resident 's placem	nent, maintenance, and care			
	in the facility.				
	(vi) In situations w	here the resident is			
	developmentally d	isabled, the regional office			
	of the division of d	isability, aging, and			
	rehabilitative servi	ces, who may assist with			
	placement decisio	ns.			
	(vii) The resident '	s physician when the			
	transfer or dischar	ge is necessary under			
	subdivision (4)(C),	(4)(D), (4)(E), or (4)(F).			
	(B) Record the rea	asons in the resident 's			
	clinical record.				
	(C) Include in the	notice the items described			
	in subdivision (9).				
	(7) Except when s	pecified in subdivision (8),			
	the notice of trans	fer or discharge required			
	under subdivision	(6) must be made by the			
	facility at least thir	ty (30) days before the			
		rred or discharged.			
	(8) Notice may be				
		transfer or discharge when:			
		idividuals in the facility			
	would be endange	<del>_</del>			
		ndividuals in the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	(X2) MULTIPL A. BUILDING B. WING	TIPLE CONSTRUCTION (X3) DATE SU  NG 00 COMPLE  09/06/20		TED	
				ET ADDRESS. CIT	TY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8		S EICKHOFF			
WEST RIVER HEALTH CAMPUS				NSVILLE, IN4			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX			ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		DEFICIENCY)		
	would be endange (C) the resident 's to allow a more in discharge; (D) an immediate required by the reneeds; or (E) a resident has thirty (30) days. (9) For health facilispecified in subdivided following: (A) The reason for (B) The effective (C) The location to transferred or disc (D) A statement in bold type that read appeal the health transfer you. If you to leave this facility request for a hear department of hea (10) days after you request a hearing twenty-three (23) notice, and you with facility earlier of a stransfer you under to appeal this transpeal the health request a hearing questions, call the health at the number (E) The name of the	ered; s health improves sufficiently amediate transfer or transfer or discharge is sident 's urgent medical not resided in the facility for lities, the written notice vision (7) must include the r transfer or discharge. date of transfer or discharge. To which the resident is	ı	(EACH CO CROSS-REF		TE	COMPLETION DATE
	the division.	lest form prescribed by the					
		dress, and telephone	1				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
155785		A. BUILDING B. WING			09/06/2011			
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER							
WEST RI	VER HEALTH CAM	IPUS	714 S EICKHOFF ROAD EVANSVILLE, IN47712					
WEST RIVER HEALTH CAMPUS								
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		DEFICIENCY)		DATE	
	number of the state and local long term care							
	ombudsman.	lity regidents with						
	(H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services							
	commission.							
	Based on record	review and interview, the	R	0045	R045Resident G suffered no ill		10/06/2011	
		ensure residents were			effects from the alleged			
		of Transfer or Discharge			deficiency as stated in the			
		nt reviewed related to			2567.All residents have the			
					potential to be affected and through inservice ad alteration	n in		
		tient hospitalization in a			procedures will ensure that r			
	sample of 1 resid	lent. (Resident G)			of transfer/discharge is issue			
					time of transfer and contains all required information.Completion			
	Findings include	:						
					Date 10-6-11Systemic change will			
	The closed clinic	eal record for Resident G			be the use of a notice of tran			
	was reviewed on	9/6/11 at 12:50 p.m.			or discharge form that contai			
		ated the resident was			the local ombudsman contact information and Discharge/Bedhold policy signed			
	admitted to the fa							
		Clifty 011 0/3/11.			on admission.Completion Date			
	a : 1a : p	N. 1 . 1			10-6-11Staff inserviced on			
		rogress Notes, dated			transfer/discharge notice and	I		
		the Director of Social			requirement to notify legal			
	Services contacte	ed three behavior units			representative at time of			
	seeking placemen	nt for evaluation and			transfer.Completion Date			
	treatment of Resi	ident G's behaviors of			10-6-11Director of Social Service/Designee will monito	r		
	throwing food tra	ays at staff and in the			transfer forms daily and conf			
	•	ning and combativeness			that notification occurs at tim			
	with staff.	and comount oness			transfer.Results of monitoring			
	with stall.				be forwarded to QA committee	ee		
	A1	1 d-4-d 7/C/11			monthly x 6 months and qua			
	A physician's ord				thereafter.We respectfully re	quest		
	-	to [name of behavior			for a desk review.			
	unit] for eval [ev	aluation] and tx						
	[treatment]."							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155785		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	(X3) DATE COMP 09/06/2	LETED			
NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF ROAD EVANSVILLE, IN47712					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	O BE	(X5) COMPLETION DATE		
TAG	Documentation is failed to indicate Discharge was is During interview the Director of S she completes the Discharge if a redischarge, such a nursing staff wor of Transfer and I transferred to the	n the closed record file a Notice of Transfer or sued to the resident.  on 9/6/11 at 3:50 p.m., ocial Services indicated e Notice of Transfer and sident has a planned as a discharge home, but ald complete the Notice Discharge if a resident is e emergency room.  g is related to Complaint	TAG	DEFICIENCY)		DATE		